Dr. Mamie Chan
ABQ Eye Care

DATE:_____ **PATIENT INFORMATION**

Whom may we thank for referring you? _____

Full Name_____ Nickname_____

Address_____ Apt#_____ City_____State_____ Zip_____

Date of Birth_____ Social Sec#_____-_____-_____ Sex: Male Female

Day Phone (_____) _____-_____ Cell Phone (_____) _____-_____ **Ok to receive Text Messages YES or NO**

EMAIL**:** _____

Info given to ABQ Eye Care is used for in Office use only. Used for notifications on appointments, eyeglasses, contacts, promos, ect.

Occupation_____ Employer_____ Full Time Part Time

Hobbies: _____

Are you: □ A Minor □ Single □ Married □ Divorced □ Other

Ethnicity: □ African American □ Asian □ Caucasian □ Hispanic □ Native American or Alaska Native □ Not Listed □ Refused

Emergency Contact Name & Number _____

MEDICAL INFORMATION

Date of Last Medical Examination_____ Name of Family Dr_____

Do you currently use: □ cigarettes/tobacco □ alcohol □ other substances □ none

Please check if you or an immediate blood relative have been diagnosed with a problem with any of the following:

□ Allergies _____	□ Eyes _____	□ Infectious _____	□ Currently Pregnant / Nursing _____
□ Arthritis _____	□ Gastrointestinal _____	□ Integumentary (skin)_____	□ Sjogren's Syndrome _____
□ Blood/Lymph_____	□ Genitourinary _____	□ Kidney / Liver Disease____	□ Thyroid Disorder _____
□ Cancer _____	□ Gout _____	□ Lupus _____	□ Tuberculosis _____
□ Cardiovascular_____	□ Heart Disease _____	□ Musculoskeletal _____	
□ Constitutional_____	□ Hematologic _____	□ Nervous _____	Other _____
□ Diabetes_____	□ High Blood Pressure _____	□ Neurological _____	_____
□ Ears/Nose/Throat ____	□ High Cholesterol _____	□ Psychiatric _____	_____
□ Endocrine (glands) ___	□ Immunologic _____	□ Respiratory _____	_____

Current Medication(s):_____ Medication(s) Allergies or Adverse Drug Reactions:

□ None _____ □ None _____

EYE INFORMATION

When was your last eye exam? _____ Which Doctor did you see?_____

Do you wear glasses? □ No □ Yes If yes how old is your current pair?_____

Do you wear contact lenses? □ No □ Yes If yes What kind / type? _____

Have you had any eye operations? □ No □ Yes If yes, what kind?_____ Date_____

Have you had any eye injury? □ No □ Yes If yes, what kind?_____ Date_____

Please check if you or an immediate blood relative has been diagnosed with any of the following:

□ Amblyopia / Lazy eye	□ Glaucoma	□ Retinitis Pigmentosa
□ Cataract	□ Macular Degeneration	□ Strabismus / Eye Turn
□ Color Vision Defect	□ Retinal Detachment	□ Other

Please check if you are currently experiencing any of the following eye symptoms:

□ Blurry Vision at Distance	□ Eyestrain	□ Infection of Eye or Eyelid	□ Mucous Discharge
□ Blurry Vision at Near	□ Flashes of Light or Floaters	□ Itching	□ Red eyes
□ Burning	□ Foreign Body Sensation	□ Light Sensitivity	□ Watering Eyes
□ Eye Pain or Soreness	□ Headaches	□ Dry Eye	□ Other_____

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